AIR FORCE MEDICAL SERVICE

(AFMS)

CONCEPT OF OPERATIONS

FOR THE

MENTAL HEALTH AUGMENTATION TEAM

(UTC FFGKU)

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SECTION 1 – GENERAL

1.1. Purpose: To provide the Concept of Operations (CONOPS) for the FFGKU Mental Health Augmentation Team (MHAT). Since the MHAT is not deployed without the FFGKV Mental Health Rapid Response Team (MHRRT), further reference to the MHAT in this document will assume the MHRRT has been deployed. This document describes the organization and relationships with the following: Command, Air Transportable Hospital (ATH), Expeditionary Medical Support (EMEDS) + 10-bed or greater Air Force Theater Hospitals (AFTHs) and other stand-alone or stand-apart Medical Treatment Facility (MTF) units. In addition this CONOPS provides generic guidance for the development and operation of the team in support of operations envisioned in Regional Operational Plans (OPLANs), exercises in which medical resources may participate, and contingency/humanitarian operations. Specific information to amplify and tailor guidance contained in this CONOPS is included in Technical Orders (T.O.s) and supporting

regional or other OPLANs. This document also develops guidance for identifying and defining MHAT responsibilities and ensuring that MHAT tasks, functions and responsibilities are properly assigned. Furthermore, this CONOPS ensures adequate resources are available to support global military operations associated with regional plans, provides a source document for developing MHAT policies, standard operating instructions (O.I.s), training programs and determines future MHAT requirements and revisions appropriate to the planning and training concepts.

1.2. Background: Information has been gathered through Wartime Medical (WAR MED) Policy and Guidance Statements. It was developed from 50 expert panels encompassing 64 specialty areas, which included the Surgeon General's specialty consultants and enlisted members. Data was compiled in a medical readiness support database (MRSD). Additional information was gathered through history, research and experiences of other mental health professionals deployed, as well as previously developed CONOPS, policies, and procedures.

1.2.1. Historically, depending upon the conflict, 15 to 35 percent of casualties have been mental health casualties. Research also reveals at least 15 percent of those who experience a physical injury also require mental health services.

1.3. Threat: The mission responsibilities for the MHAT exposes the team to a variety of threats to include: non-battle injury (endemic disease, climate, terrain and socioeconomic conditions), conventional and unconventional weapons (precision guided munitions, antipersonnel/vehicle mines, tube and rocket artillery, aerial bombs, unmanned aerial vehicles [UAVs], cruise missiles, ballistic missiles, airborne carbon fibers, metal-embrittling liquids, high-powered microwave and directed energy weapons), weapons of mass destruction, and assault by hostile forces as well as potentially violent patients.

SECTION 2 - DESCRIPTION

2.1. Mission/Tasks: To provide personnel and equipment to augment the FFGKV Mental Health Rapid Response Team (MHRRT), for mental health triage and stabilization, critical incident stress management (CISM), command consultation and outreach services (education, health promotions and stress management), and management of combat stress casualties in a 20-bed facility. The team is a flexible module that, in conjunction with a MHRRT can form the basic mental health team to enhance the medical services of an ATH/EMEDS - AFTH. The MHAT exists to support the MHRRT and will never deploy without the MHRRT.

2.2. Description/Capabilities: The MHAT, when deployed with the MHRRT can serve as a stand-apart facility or as part of a 10- 25- 50- or 114-bed facility. The current configuration of the MHAT is 6 members. This team augments the MHRRT to provide preventative, educational, consultative, and treatment interventions. These services include outpatient mental health treatment (psychotherapy and medications), CISM, command and ATH/EMEDS - AFTH consultation, short-term inpatient psychiatric services (evaluation, stabilization and detoxification while mental health patients receive care on the general medical wards), and consultation to the medical-surgical wards. For

inpatients whose mental health conditions do not begin to respond to interventions within 72 hours, the team will arrange air evacuation (AE) to the next level of care. The team will need standard laboratory plus toxicology screens and blood alcohol levels, and basic pharmacy. In addition, the MHAT will require the psychotropic medications on the MHAT's Allowance Standards (AS). The team members should also be trained and competent in basic medical skills as identified in the core competencies. The MHAT in conjunction with the Emergency Department (ER) and Medical Command and Control (MCC) will coordinate the duress system and training of personnel for restraint teams to manage potentially violent patients. In general, each bed-down with a population at risk of 2000 or greater will be supported by a Mental Health Rapid Response Team. In addition, in general a Mental Health Augmentation Team will be available within 12 hours, or when significant numbers of combat stress casualties are likely. Deployment of the Mental Health Rapid Response Team at bed-downs with populations under 2000 may be necessary in response to a critical event.

2.2.1. The MHAT, when deployed with MHRRT, will provide preventative, outpatient, inpatient and outreach mental health services as well as consultation liaison services for Command, the ATH/EMEDS - AFTH or other customers as determined by the treatment setting or OPLAN (refugee care, hostage negotiation, humanitarian efforts, etc.). Services/treatment could range from a one-time intervention to an inpatient treatment/stabilization regimen. In conjunction with a MHRRT, the MHAT could provide intensive mental health services for new ambulatory patients each day. Together the teams would also be able to manage 25 additional minimal care "combat stress" casualties (with the provision of 20 beds and the remainder outpatient), and to support additional mental health casualties and detoxification patients in an inpatient setting on the general medical wards.

2.2.2. The MHAT is composed of: one psychiatrist, three mental health nurses, and two mental health technicians. The MHAT is only deployed with the MHRRT. The MHRRT and MHAT can operate a combat stress facility (CSF) with 12-hour shifts, 24 hours per day, seven days a week for a sustained period of time. With this team and potential team complements, members from the MHRRT are able to further deploy to address consultation and short-term crisis intervention needs.

2.2.3. The team's functional capacity does not include ongoing inpatient mental health consultation without anticipation of quick symptom resolution. With the overall goal of rapidly returning members back to their units to secure unit effectiveness, team work and espirit de corps, inpatient care could occur for the following reasons: temporary observation when return to duty is expected within three days or emergent hospitalization for safety while awaiting imminent evacuation to the next level of care (expected for psychosis, severe mood disorders, or severe combat stress reactions).

2.2.3.1. There is no stand-alone (or stand-apart) inpatient mental health unit. Individuals requiring inpatient mental health care will receive treatment on the general medical wards under the care of an attending ward physician with regular mental health consultation-liaison. No mental health inpatients will be housed in the OPMHC (generally located in a

dedicated space within the ATH/EMEDS - AFTH). The OPMHC is strictly an outpatient facility. Only combat stress casualties will be housed in the CSF.

2.2.4. Equipment: See Allowance Standards (AS).

2.2.4.1. Medication: 1) The MHAT will deploy with a 30-day supply of medication relevant to mental health care; 2) While in transit to the deployment site, the MHRRT is required to retain physical possession of all Schedule IV drugs. A letter will be required from the deploying team's pharmacy explaining why the Schedule IV drugs are in the team's carry-on luggage; 3) Refrigeration of the Ativan helps retain its potency, but the manufacturer has indicated it may be stored at room temperature for 1 to 3 months and may even be refrigerated in something as simple as a cooler.

2.2.4.2. Tentage: The MHAT's AS will include one 64-foot tent which will operate as an CSF.

2.2.4.3. Power Requirement: Since the CSF is designed to possess the capacity to serve as a stand-apart unit, the facility will require an environmental control unit (ECU) and a heater (logistics indicates the ECU's heater is insufficient to heat in a demanding cold environment) for a total of 1 ECU's and 1 heater. In light of the required stand-apart capacity, a generator is required to power this facility and enough cable should be included to allow it to stand 50 yards from the ATH/EMEDS - AFTH or a secondary distribution panel. Thus one generator and at least 50 yards of cable are required. In addition, a power distribution unit and appropriate cables are required.

2.2.4.4. Transportation: Authorization for a vehicle is essential since the mission involves a great deal of prevention and education at the unit level throughout the area of responsibility.

2.2.4.5. Professional Gear: Due to professional preferences and the tendency of material to become dated, no reference material will be included in the equipment package. Instead, mental health providers are encouraged to bring their preferred professional reference materials.

SECTION 3 - OPERATIONS

3.1. Employment:

3.1.1. Assumptions.

3.1.1.1. Base civil engineers will be responsible for maintenance of equipment (e.g. generators, heaters, air conditioning, etc.). Other base support services such as billeting, food service, sewage and waste disposal, potable water, power, transportation and communication will be available to support MHAT needs.

3.1.1.2. The MHAT is presently a six member team. The team will augment a MHRRT when additional personnel and/or equipment are required to support the mission.

3.1.1.3. Casualties who may be contaminated with chemical/biological warfare (CBW) agents will initially be managed by the patient decontamination team. Base support will be required for any decontamination of the MHAT prior to and after operational use.

3.1.1.4. Normally casualties requiring evacuation can be housed on the ATH/EMEDS - AFTH ward as determined by the theater evacuation policy. The decision to evacuate patients is made by the patient's attending provider. The MHAT will advise the AE clerk regarding patients needing evacuation and will continue to observe and treat these patients until transfer occurs. Coordination will be required with the AE clerk for provision of restraints and litters that will travel with patients. The AE staff need to provide their own restraints to ensure the restraints of the mental health staff are not depleted through evacuation. AE clerks must pre-coordinate with Global Patient Movement Requirements Center (GPMRC)/Theater Patient Movement Requirements Center (TPMRC). The most preferred disposition of patients shall be treatment in the theater of operations with return to duty.

3.1.1.5. The preferred method of referral for those requiring mental health services should be via verbal or written consults from hospital Triage, Emergency Services, or Primary Care. However, referrals from other sources will be accepted, including self-referral. Another extremely important mental health contact with patients will be in the context of preventive services, frequently offered off-site.

3.2. General: Upon arrival at an operational site, the MHAT will be fully operational in 24
hours.

3.2.1. The OPMHC will generally be provided by a dedicated space within the ATH/EMEDS - AFTH. If a stand-apart OPMHC is established utilizing a tent of opportunity, it will ideally be erected as a stand-apart unit that is not co-located with the ATH/EMEDS - AFTH. The OPMHC should be physically located away from the ATH/EMEDS - AFTH and near the personnel housing area and/or an aid station, if one is established. If the OPMHC cannot be located in the personnel housing area, the next best location is 50 to 100 yards from the ATH/EMEDS - AFTH. If a stand-apart facility is created it should be separate from but within 50 to 100 yards of the CSF. Tent placement should take into consideration patient safety, the ability of the therapist and patient to talk without the conversation being overheard, and high traffic areas should be avoided.

3.2.2. If the CSF is established, it will ideally be erected as a stand-apart unit that is not co-located with the ATH/EMEDS - AFTH. The CSF should be physically located away from the ATH/EMEDS - AFTH and near the personnel housing area and/or an aid station, if one is established. If the CSF cannot be located in the personnel housing area, the next best location is 100 to 200 yards from the ATH/EMEDS - AFTH. The CSF should be separate from but within 50 to 100 yards of the OPMHC (if in the stand-apart mode). Tent placement should take into consideration patient safety, the ability of the therapist and patient to talk without the conversation being overheard, and high traffic areas should be avoided. In addition, it is very important to remember the CSF is to be located near the battlefront not at the rear. Treatment of combat stress casualties at the

rear have resulted in return to duty rates (RTD) as low as 3% versus the RTD of 80-90% when these individuals are treated near their units in the vicinity of the battle.

3.3. Deployment: Deployment planning and preparation are essential to support the MHAT operational objectives during wartime or other contingencies. The MHAT must be afforded sufficient command support to ensure unit readiness. Generally, mobilization begins with a recall issued by the wing or flight commander. The MHRRT and MHAT may be required to be self-sufficient until other mental health resources are deployed, should the deployment scenario require additional mental health resources. In a contingency operation, flexibility and adaptability are required, as each scenario is different. However, the main goal of patient care remains the same.

3.4. Redeployment: When deployment operations end, equipment will be cleaned, repackaged, and prepared for transportation. If there is nuclear/biological/chemical (NBC) contamination, the system must be certified decontaminated from NBC hazards prior to striking.

SECTION 4- COMMAND & CONTROL RELATIONSHIP STRUCTURE

4.1. HQ ACC/SG will maintain overall advocacy for Expeditionary Medical Support and Air Force Theater Hospital policy and serve as the medical consultant for technical guidance and deliberate planning for ATH/EMEDS - AFTH operations. HQ AMC/SG will maintain overall advocacy for this team.

4.2. The MHAT will be under the command of the team's most senior officer qualified for command. The team chief will report to the Director of Base Medical Services (DBMS) or the ATH/EMEDS - AFTH commander. When deployed, the MHAT will form an integrated unit with the MHRRT. The chief of the combined MHAT/MHRRT unit will be the most senior officer qualified for command. This will be determined by the DBMS or the ATH/EMEDS - AFTH commander.

4.3. The command arrangements for individual ATH/EMEDS - AFTHs employed in support of a particular contingency operation will be outlined in their respective Operational Plans/Execution Orders and will be specific to the operation and theater supported.

SECTION 5 - INTELLIGENCE/NATIONAL AGENCY/SPACE SUPPORT

5.1. Intelligence: Accurate medical intelligence is vital to threat identification and application of appropriate preventative measures. Medical intelligence information will be the responsibility of the medical intelligence officer (usually the Public Health Officer). Information will be disseminated throughout the ATH/EMEDS - AFTH as indicated.

SECTION 6 - COMMUNICATION/COMPUTER SUPPORT

6.1. Computers: A laptop computer, mouse, phone modem, and portable printer, are vital for completing the mental health mission. The computer equipment will greatly reduce the weight the team must carry by eliminating the binders currently containing hard

copies of forms, procedures, OI's, AFI's, diagnostic work-ups, prevention handouts, workshop presentations, etc. The computer will allow the team to: engage in tele-medicine; obtain administrative and clinical input from Walter Reed Army Medical Center, Wilford Hall Medical Center, and Malcolm Grow Medical Center's CHCS consultation service; access the local ATH/EMEDS - AFTH or military hospital's LAN/CHCS network; access Air Force internet sites for publications, forms, and OI's; compile clinical databases on patient demographics, diagnoses, treatment outcomes, etc.; create deployment specific prevention literature for distribution; develop advertising flyers for mental health services; perform command directed mental health evaluations; conduct psychological testing, etc. Optical scanners would be required to perform standardized psychological testing for evaluations like a Commander Directed Evaluation.

6.2. Photocopying and Faxing: Availability to photocopying and facsimile equipment is needed as well.

6.3. Radios: The six-member MHAT and three-person MHRRT may be required to operate both an OPMHC and a CSF 24 hours which means only one to two providers may be present at any one time in each clinic. There will be many times when one provider will be performing services outside the clinic leaving one person behind who may be unable to handle a high-risk situation that develops at short notice. Radios are needed to communicate with the hospital, fellow mental health staff members away from the clinic, and to request security assistance should high-risk situations evolve. Thus the MHAT needs two radios (one for the CSF and one for the absent mental health staff member) and the MHRRT needs two radios (one for the OPMHC and one for the absent mental health staff member) for a total of four radios.

6.4**.** MEDRED-C: Daily information about the ATH/EMEDS - AFTH's status of operations is communicated in the MEDRED-C. This report is accomplished daily and communicates to the unit's parent and gaining MAJCOM SG, as well as the theater commander. This report provides information on the operational readiness status, unit availability and patient care activities of USAF Medical Service units on alert for contingency operations or which have come under the influence of an unusual occurrence (i.e. natural disaster or other emergencies). The MHAT could use this information to gather or to disseminate information from or to units to make vital and efficacious patient care decisions.

6.5. Patient Privacy and Confidentiality: All patient care information needs to be safeguarded to address patient privacy and confidentiality. Documentation for aerovac purposes will be brief but adequate enough to ensure continuity of care. Medical or casualty information can become an operations security (OPSEC) issue when linked to a particular military mission or operation. While medical information itself is not classified, in the context of a mission, it can be protected as part of the CINC's overall OPSEC program to deny information to the enemy.

SECTION 7 - INTEGRATION & INTEROPERABILITY

7.1. Integration With Other Systems: To successfully accomplish MHAT's mission and provide efficacious patient care, the MHAT and MHRRT must integrate with other

clinical services, the base support services, commanders, and chaplains. A good working relationship with the staging facility to coordinate AE of mental health patients is strongly encouraged.

2. Referrals:

7.2.1. OPMHC Referrals: The ATH/EMEDS - AFTH and other specialty units can request mental health consultation through a variety of channels. The preferred method of referral for those requiring mental health services should be via verbal or written consults from hospital Triage, Emergency Services, or Primary Care. However, referrals from other sources will be accepted, including self-referral. Periodic briefings will be given to the referral sources on how and who to refer.

7.2.2. CSF Referrals: All CSF referrals must originate with an assessment by the provider on-call for the OPMHC who will determine the patient's appropriateness for the CSF.

7.3. Interoperability: MHAT services will be provided to all casualties as regulated by the patient medical regulating office for the ATH/EMEDS - AFTH, TPMRC, GPMRC and the Aeromedical Evacuation Liaison Team (AELT). These offices may regulate services for joint service members, allied service members, foreign nationals, etc., depending on the contingency, the geo-political situation as well as ATH/EMEDS - AFTH and MHAT resource availability.

SECTION 8 - SECURITY

8.1. Operations: Security for patients and personnel resources within their immediate area at each ATH/EMEDS - AFTH site is an ATH/EMEDS - AFTH responsibility. The MHAT will respond as requested to participate in security maintenance for the ATH/EMEDS - AFTH.

8.2. Physical: Security begins with education and awareness. The MHAT will respond accordingly to all protective measures as outlined in security briefings. Physical security of the MHAT and their casualties will be the responsibility of the BOS security forces. The MHAT may implement additional security measures within their immediate work area as threats, intelligence and other information is evaluated.

SECTION 9 - TRAINING

9.1. Equipment Training: Personnel should be familiar with the equipment on the AS of both the MHAT and MHRRT. Special attention should be given to erection of the tentage on the MHAT's AS. The entire equipment package should be unpacked and set up on an annual basis as part of Continuing Medical Readiness Training (CMRT).

9.2. Clinical Training should run the gamut from outreach and prevention to severe mental illness. Handouts should be developed on common mental health issues that can later be tailored to the specific deployment. Combat stress and CISM are to receive

special emphasis. The training will be based on the military specific training modules developed by the Air Force Combat Stress Working Group (AFCSWG). Binders will be developed that contain pertinent presentations, forms, procedures, OI's, AFI's diagnostic treatment protocols, etc. The material in the binders will also be placed upon CDs. The hard copies in the binders will be used for training purposes at the team's home base while the CDs will accompany the MHAT on deployment.

9.3. Exercises: Exercises should involve realistic presentation of mental health needs that actually occur. Readiness planners must obtain input from knowledgeable mental health consultants when planning exercises.

SECTION 10 - LOGISTICS

10.1. Medical Supplies: See AS.

10.2. Storage Requirements: The MHAT supplies are stored with the ATH/EMEDS - AFTH in a ready mode for rapid deployment. Equipment designed for use in the CSF may be stored separately to reduce the shipping weight should the MHAT deploy solely to assist with the establishment of a CSF.

10.3. Initial Response Supplies: The MHAT will be deployed with sufficient supplies and equipment to operate for 30 days without resupply.

10.4. Resupply: The MHAT resupply requests will be coordinated through medical logistics. They will coordinate with the Air Force Forces (AFFOR) Surgeon and the host medical supply account to ensure regular resupply and uninterrupted services.

SECTION 11 - SUMMARY

The MHAT will never deploy without the MHRRT. The mission of the MHAT is to augment the MHRRT with personnel and equipment in order to deploy worldwide to support various contingency operations. By design, the MHAT can be tailored and deployed to meet theater CINC requirements. With various staffing complements the MHAT can support the MTF and all likely contingency needs while ensuring an optimum level of wellness for the supported population.

SECTION 12 - GLOSSARY OF TERMS

<u>Abbreviations Definitions</u>

ACC Air Combat Command
AE Aeromedical Evacuation
AELT Aeromedical Evacuation Liaison Team
AFCSWG Air Force Combat Stress Working Group
AFFOR Air Force Forces
AFMIC Air Force Medical Intelligence Center
AFTH Air Force Theater Hospital

AMC Air Mobility Command
AS Allowance Standards
ASAP As Soon As Possible
ASTS Aeromedical Staging Squadron
ATH Air Transportable Hospital
BOS Base Operational Support
CBW Chemical Biological Warfare
CINC Commander-in-Chief
CISM Critical Incident Stress Management
CONOPS Concept of Operations
CSF Combat Stress Facility
DEPMEDS Deployable Medical Systems
DIA Defense Intelligence Agency
ECU Environmental Control Unit
ER Emergency Room
EMEDS Expeditionary Medical Support
GPMRC Global Patient Movement Requirement Center
INTEL Intelligence
JMRO Joint Medical Regulating Office
LMR Land Mobile Radio
MAJCOM Major Command
MCC Medical Command and Control
MHAT Mental Health Augmentation Team
MHRRT Mental Health Rapid Response Team
MOOTW Military Operations Other Than War
MRSD Medical Readiness Support Database
MTF Medical Treatment Facility
NBC Nuclear/Biological/Chemical
OIs Operational Instructions
OPLANS Operational Plans
OPMHC Outpatient Mental Health Clinic
OPSEC Operations Security
PMI Patient Movement Items
RTD Return to Duty
SATCOM Satellite Communications
SG Surgeon General
TO Technical Orders
TPMRC Theater Patient Movement Requirements Center
UAV Unmanned Aerial Vehicle
UTC Unit Type Code
WARMED Wartime Medical
WMR War Readiness Material